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ABSTRACT

This paper highlights what the authors believe are the important issues and directions of change in the evaluation of mental health programs. The rationale for such evaluation is twofold. First, it provides a scientifically rigorous method of determining the therapeutic efficacy of the treatment or program, and secondly, these results can exercise a feedback into the system, modifying the clinical operations. The major types of evaluation studies are considered: intra-institutional studies, effect of relocation from one institution to another, alternative treatments upon admission to institutions, and alternatives to institutionalization. Further issues considered include contented vs. angry patients, patient deterioration, and covert deterioration which is less obvious to the observer. It is considered that the best hope for the future is a comprehensive mental health system with many flexible alternatives, integration of community and institution, and continuity of care. Extensive references are included. (Author/SES)

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Evaluation of Mental Health Programs for the Aged

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The Evaluation of Mental Health Programs for the Aged

Some years ago one of us was engaged in a research study of a number of institutions providing services for the aged, and one day came to a home for the aged that he and his colleagues considered to be one of the worst, if not the very worst, institution they had ever seen. Almost all the residents were psychotic or deteriorated, sitting like zombies in their foul-smelling rooms or shrieking some delusion or hallucination in the halls, many of them in restraints. With our gallows humor reaction to the place, my colleagues and I threatened one another with being locked up for two hours on one of the floors, guaranteeing that the victim would come out raving. Yet, as we left one day we ran into some members of the Board of Trustees, and after introductions and the usual polite interchanges, the President of the Board, with a big smile on his face, enunciated, "our people come here to live and not to die." One gets used to the clichés in the field, but the contrast between this man's evident pride and our own depression was startling, and we were overwhelmed with the necessity for evaluation studies. In the fifteen years since then there have been many developments in evaluation of programs for the aged, but the clichés, the poor programs and the differences of opinion continue.

The importance of evaluation in mental health programs has been increasingly established in recent years, supported by the need to screen the many psychopharmacologic agents that have appeared, and conceptually and operationally built into community mental health center programs. The rationale of evaluation is twofold: first, that it provides a scientifically rigorous method of determining the therapeutic efficacy of the treatment or

program, and secondly, that these results can exercise a feedback into the system, modifying the clinical operations. Ideally, such a system should lead inevitably to constant improvement of levels of care, a survival of the fittest, reinforcing good programs and discouraging those that are poorer.

The purpose of this chapter is to highlight what we believe are the important issues and the directions of change that are indicated. We will consider some of the usual Who, How and What variables -- the specifications of the population studied, the procedures and interventions that were carried out, and the evaluative criteria employed. From a broader perspective the nature of the population studied and the intervention and evaluation procedures employed are related to a system of values and expectations which are characteristically implicit. These goals and assumptions, which are hardly hinted at in the restricted statements of explicit goals, could be called the Why of the study, and need to be taken into account to place the individual studies in a proper context.

We will consider the major types of evaluation studies, including some of the important population or subject issues, and examine the complicated question of evaluation criteria.

Types of Studies

Intra-institutional Studies

The basic design of the intra-institutional study is the introduction of a program for the inmates that is expected to have some ameliorative effect. One basic objection to such studies is that it is not clear what is being affected, the mental disorder itself, the effects of the institution, or

the interaction of the two. In any case, the results of intra-institutional improvement studies suggest the general conclusion that almost anything helps, but nothing helps very much. These programs range from extensive milieu or rehabilitation treatment plans in which a variety of techniques are offered such as physical therapy, individual therapy, occupational therapy, work programs and, most frequently, some sort of social group, to more limited studies which employ one or two of these basic mental health techniques. No matter what the treatment, the results are generally described as favorable in such terms as "improved self concept," "increased group interaction," "more adaptive behavior," "activity and conversations increased" (Donahue et al., 1960; Gottesman, 1965; Rechtschaffen et al., 1954; Pappas et al., 1958; Cosin et al., 1958).

But even granting that such loosely defined and measured criteria mean anything, in the context of the primitive conditions and prevailing custodial attitudes within the institutions it is likely that any change introduced is likely to have some sort of improvement. Lieberman (1969) feels that this described change may well be a manifestation of a "Hawthorne" effect, in which any alteration in a boring and repetitive situation leads to increased behavioral output. One of us was studying patients in a particularly bad nursing home when a breakdown in the heating system led the usually withdrawn patients to huddle together for warmth and to a general increase in social interaction. In this case, an additional negative stimulus led to the same kind of improvement as reported with more benign planned changes.

There are many reservations about the intra-institutional studies. Improvements in functioning may be transitory, with behavior declining following the cessation of the intensive therapy (Pappas et al., 1958; Cosin et al., 1958). This is apparently the case even when the institution's

staff has been especially trained in methods to counteract the harmful effects of custodial treatment (Penchansky and Taubenhaus, 1965). Negative behavior may also result from the treatment. Jones (1972) was able to increase social interaction through recreation therapy in a nursing home, but also noted much conflict, hostility and mistrust among the patients during the program. Changes within an institution may have little bearing on subsequent behavior (Erickson, 1962). In working with an adult hospitalized population, Forsyth and Fairweather (1961) found that the criteria of improvement within the institution, such as ward behavior ratings and MMPI scales, showed no relation to criteria of adjustment six months after discharge. Increased discharge rate is frequently used as an evaluation measure of a program's success, but this is equivocal, as it may well be more of an administrative decision than a reflection of substantial differences in the patients.

Behavior modification techniques appear to have obtained results comparable to other methods, and are subject to the same criticisms, although the number of studies on institutionalized geriatric subjects is limited (Cautela, 1966). Methodological discussions of behavior modification and aging have been contributed by Lindsley (1964) and Cohen (1967). Cautela (1969) has described the utilization of such techniques as relaxation, desensitization and thought stopping, necessarily restricting himself to the less impaired patients. Libb and Clements (1969) used a token reinforcement system with four severely impaired patients and found some increase in rate of performance on an exercise task. Filer and O'Connell (1964) worked in a large V.A. domiciliary and operated a system of consistent and discriminate rewards and feedback. Grossman and Kilian (1972) attempted to apply the principles of the token economy on a

mixed ward containing both chronic schizophrenic and senile geriatric patients. They felt the program was a success for most patients in improving their grooming and social interaction, but that it was very fragile and was not maintained without the leaders' presence, and had negative consequences such as increasing staff friction, inducing regression in at least one patient, and being unsuccessful with patients who were extremely depressed and withdrawn or who had severe organic impairment. Davison (1969), in an appraisal of behavior modification techniques with adults in institutional settings criticizes such studies as those of Ayllon and Azrin (1968) by indicating that some behaviors could not be modified, particularly self-care, and that undesirable mechanisms were also reinforced.

One of the most glaring difficulties of these studies is in the peculiar definition of a geriatric population in state mental hospitals. These include chronic schizophrenics and persons with other chronic mental disorders with long histories of illness, some having been hospitalized for as much as forty years or longer. Although it is useful to study changes in these patients with increasing age, it is absurd to mix them up in a heterogeneous hodge-podge with patients whose mental disorders occurred late in life and consider the whole thing a "geriatric" study. These chronic patients are so different in so many critical areas that they should be studied separately. A chronic schizophrenic at age 75 who has been institutionalized for thirty years undoubtedly has more resemblance to another schizophrenic fifty years old and hospitalized for thirty years than with another 75 year old with a six month history of impaired behavior following a stroke.

To combine such diverse patients in an undifferentiated study seems so patently in error that it would seem surprising that it is done so

much. The explanation may be found, we believe, in the administrative practices of state mental hospitals in the context of our historic tradition of negative stereotypes about the aged. In state hospitals services are organized by chronological age, and the geriatric service is usually for all patients 65 years of age and older. Accordingly, when a patient in one of the other wards reaches his 65th birthday he is automatically transferred to the geriatric unit. He may have been on one ward for many years with other chronic patients, but he is now transferred as though he were a different kind of problem and needed a different staff. When new aged patients are admitted to the hospital they also go into the geriatric unit, and the whole melange is treated as "geriatric." Because of our negative stereotypes about aging, those who establish intervention programs in these units may go unquestioningly along with this characterization, accepting all the distortions introduced by the contamination of populations, whether it is the apathy and withdrawal of institutionalism confused with the effects of aging, or inaccurate perception of the true geriatric problems because of the schizophrenics' superior cognitive functioning.

Since the chronic patients had already shown difficulty in responding to the hospital treatment program it is unlikely that the shift to a geriatric ward will make much difference. While working with chronic schizophrenics has its own merits, these intractable institutionalized subjects give a negative therapeutic aura to all aged persons. In actual studies the inclusion of schizophrenics distorts our understanding of the effect of a given mental health program on persons with the mental disorders of later life.

Very similar in its effect to the inclusion of schizophrenics, is the preoccupation with chronic institutionalized populations in many studies.

With so many old persons institutionalized, and with so many of them showing mental disorders (Goldfarb, 1962) they seem to represent both a convenient and appropriate population for study. But focusing on such patients limits to an extreme the kind of questions or interventions that can be studied. They suffer from institutionalism, which has been defined as a "syndrome which develops in an institutional setting that limits the individual's capacity for extra-institutional living." (Ochberg, Zarcone and Hamburg, 1972). As Macmillan (1958) and others (e.g., Wing and Brown, 1970) have pointed out, the deleterious effect of the institution may be greater than the mental disorder itself. Therapeutic interactions in such a setting may just be attempts at reversing the very difficulties we have brought on by institutionalization rather than by mental problems of aging. This leads to a circular process in which the poor results serve to confirm the notion that the aged are so disabled as to have required institutionalization in the first place.

Let us consider two of the most important, well-controlled studies of chronic populations which exemplify the difficulties of intra-institutional programs.

One of the most elaborate was that reported by Kelman (1962). An ambitious experiment in the rehabilitation of nursing home patients was undertaken by a cooperative group of leaders in rehabilitation medicine and public health in New York City. Despite earlier reports of the negative effects of rehabilitation programs with nursing home populations (Reynolds et al., 1959; Moskowitz et al., 1960) they undertook an especially intensive effort to alter the level of self-care, including transfer to special rehabilitation institutions. The study was based on the observation that there was a discrepancy between the poor self-care clinically shown by

the patients in the nursing home and the abilities they demonstrated when tested in the hospital. Their experimental design employed matched samples of randomly assigned treated and untreated patients, 89 percent of whom were over age 60, compared before and after one year of intervention. The change criteria were levels of function in ambulation, dressing, feeding, toileting and transfer skills. The subjects were all welfare recipients residing in a group of proprietary nursing homes in New York City, who had physical impairments limiting function in one or more self-care areas. Originally there were two treatment and two control groups, with about 100 patients in each. One treatment group remained in the nursing home, were evaluated by a mobile rehabilitation team consisting of a psychiatrist, social worker, physical and occupational therapists, speech therapist, nurse, psychologist and group worker. The team devised and carried out an individually planned therapeutic program for each patient. The hospital treatment group were transferred to an established rehabilitation hospital where they received the regular program and then returned to the nursing home. One control group consisted of similar patients in nursing homes not part of the regular study to avoid any contamination effects. A third, unintentional, control group were the somewhat more than half of those selected for transfer to the rehabilitation hospital who actually refused to go.

The results showed no difference between the experimental and control groups and no significant change within any group. All groups contained some patients who improved and somewhat more who got worse with most remaining the same. About one-fifth of all patients died at the end of the year.

In their attempt to explain their negative results, it was pointed out that the patients were chronically ill, had mostly been institutionalized

for over a year, were financially dependent, tended to have no actively interested families, and were all drawn from low and marginal socio-economic groups. Clinically the patients were apathetic and reluctant participants in the rehabilitation process. It required intense exhortation to get even a minority of the designated group to the hospital treatment centers.

The rehabilitation goals of more independent self-care had little relevance to either the patients or the nursing home staff. The patients were either so depressed and pessimistic about their futures, or were ideologically opposed, feeling that they had a "right" to be cared for. The nursing home staff felt that improved, but not complete, independence in functioning only led to greater demands on their time and energy.

There have also been elaborate studies of efforts to improve behavior in homes for the aged. Probably the most ambitious and sophisticated have been the studies undertaken at the Philadelphia Geriatric Center (Brody et al., 1971; Kleban and Brody, 1972; Kleban et al., 1971). They started out with the observation that functional incapacity is frequently greater than that warranted by the actual impairment. This observation was also the basis of the Kelman (1962) nursing home study and was reported by Kahn (1965) to be a widespread characteristic of aged persons in institutions, and which he termed "excess disability." In the Philadelphia Geriatric Center studies 32 matched pairs of women, mean ages in the early 80's, were evaluated for individual areas of excess disability such as mobility, personal self-care, social or family relationships, organized activities, individualized activities and emotional discomfort. Each person had a baseline determination and was elaborately evaluated by the usual extensive interdisciplinary team on the basis of history, observation, and meetings with the family. Each person was also evaluated on 109 different

different variables on ten different tests. During the one year study the staff worked intensively as they saw fit with each experimental subject, while the controls received the usual institutional program. When the year was up each person was reevaluated for his excess disabilities and his behavior on the 109 variables. In addition, outside observers were brought in to evaluate the change in excess disabilities on the basis of chart and other staff notes.

The results showed that both experimental and control groups improved with respect to their excess disabilities, but that for two areas, family relationships and individualized activities, the experimental group did significantly better. A significant degree of improvement for those medical disabilities diagnosed as excess was found for both experimental and control subjects. On the 109 variables significant change occurred for both groups, and for only five was the difference between the groups significant.

Combining these meagre results with the death toll, 31 percent in the experimental group and 18 percent of the controls, indicates a very minimal outcome.

The difficulties encountered by these well-designed, intensive studies such as those of Kelman and the Philadelphia Geriatric Center indicate that, although their attempt to provide humane, individualized care for the institutionalized aged is laudable, the results are not worth the effort. At this stage of our knowledge, however, we must assume that these poor outcomes reflect on the deteriorative effect of institutions rather than the intractibility of the aged.

Effect of Changes in Institutionalization: Relocation

A special type of study in recent years has been on the effect of relocation of aged persons from one institutional setting to another. Already suffering from chronic institutionalization these persons have

proved to be very vulnerable to transfer from state hospitals to nursing homes (Jasnau, 1967), or from an old home for the aged to a new one (Kral et al., 1968; Markus et al., 1972; Aldrich and Mendkoff, 1963), or transfer from one hospital ward to another because of fire (Aleksandrowicz, 1961), with significant increases in mortality frequently, but not always, occurring. Lieberman (1961) has noted a similar increase in mortality when persons on a waiting list for admission to a home for the aged finally enter. The various studies are not consistent in identification of predictive factors, although persons with brain syndromes are generally reported with the highest death rates (Blenkner, 1967).

Admission to Institutions: Alternative Treatment

What has been done in the way of effective programming at the point of admission to the institution before the chronic effects set in?

Sklar and O'Neill (1961) randomly assigned newly admitted patients to an "intensive treatment" geriatric ward and a control group to a regular hospital ward. Although their experimental group had a markedly higher return rate to the community, their results are contaminated by the fact that as part of their intensive care they had a social worker to make placement plans with the family, obviously facilitating discharge.

An unusually effective and important study influenced by the critical views of institutions of Goffman (1957) and Kleemeier (1963), has been conducted by Kahana and Kahana (1970) on the factor of age-segregation in a mental hospital. They took 55 consecutive male admissions 60 years of age and older and randomly assigned them to one of three wards, an age-segregated custodial ward with only aged patients, an age-integrated custodial ward which included the whole adult range, and a special therapy ward which, although having only aged patients, had small numbers, a mixture of men and women, a high staff ration, and an intense activity program. Each

patient was evaluated for interaction in the areas of affect, responsiveness to the environment and mental status, by means of interviews, naturalistic observations and staff ratings. Retesting was done after three weeks, which was the outer limit of the hospital system's tolerance of the random assignments. They found that patients placed in the age-integrated custodial ward and in the therapy ward showed significantly greater improvement in responsiveness and mental status than those in the age-segregated custodial ward.

Several factors are considered to have contributed to the results differentiating the age-integrated and segregated wards. Even though both were custodial, the integrated ward provided different role models because of having younger patients. There was more general activity, more visiting, more hope and more planning to leave the hospital. Two social workers were assigned to this ward while the age-segregated ward obtained social service aid only upon special request. Contrary to the expectations of some that the older persons would suffer from the activity and demands of the younger patients, they, in fact, benefitted from special priveleges. Younger patients offered their superior physical and intellectual resources in a non-reciprocating friendship pattern, walking them to meals, showers and the canteen, and allowing them to spend time outside the ward because a younger patient was watching them. The older persons were given such privileges as being allowed to go to the front of the foodline and taking afternoon naps, and aides were more tolerant of incontinence, even passing it off as an accident. The services of the half-time physician, being less in demand by the younger patients, were more readily available to the aged patients. Finally, on the age-integrated ward the aged developed a group cohesion and would help some of their feeble contemporaries, while on the

age-segregated ward they seemed to have lost "even the identity of an old person."

This finding is analogous to the celebrated Skeels (1966) study in which he followed institutionalized children for 30 years. He found that young children of normal intelligence who were raised in an orphan asylum deteriorated in time to the level of retardation and had to be kept in institutions, while children who initially tested as mentally retarded and were transferred to an institution for the retarded grew up to have normal intellectual functioning and to lead normal lives in the community. Skeels accounted for the dramatic increase in the functioning of the children originally placed in the institution for the retarded by their uniqueness because of their being much younger than the other inmates. They consequently received much fussing and stimulation and privilege.

The Kahana study represents a rarity, a well-controlled evaluative study demonstrating the application of theory to a type of intervention which is significantly effective. It should also be emphasized that her study is a clear-cut demonstration of the effectiveness of a special therapy ward with a newly admitted population, although such a program is obviously much more expensive than her age-integrated custodial ward.

But the significance of her study must be qualified, partly because of her inclusion of patients with chronic disorders although she handles their data separately, and mainly because she excludes non-testables. This was a response to the pragmatic realities of the situation, since non-testables very likely would not have been tolerated on the research wards. But, much as errors of inclusion, such as combining chronic schizophrenics and persons with mental disorders of old age, exclusion errors can also be a significant problem in evaluation of mental health studies in the aged. This is expressed

through the classic exclusion criterion of "testability" which is so characteristic of psychological methodology. The very need for evaluation data with its emphasis on tests thus can have the effect of paradoxically transforming the process it is designed to measure. It is likely that the non-testables, including even those who have died, may be the most critical subjects for the particular program being studied. Testability is largely affected by such factors as degree of cerebral impairment, severe depression and paranoid behavior, obviously major mental health problems of the aged. Meanwhile, we can applaud those researchers who have recognized the importance of total sampling, such as expressed so vividly by Markus et al. (1972) in a study on relocation: all residents were interviewed, they said, "whether or not they were bedridden, 'out of touch,' too sick or senile to be seen in the opinion of the nursing staff."

Alternatives to Institutionalization

In his review of the effects of institutionalization on the aged, Lieberman (1969) has summarized the many studies showing increased mortality rates and noxious psychological characteristics as "poor adjustment, depression and unhappiness, intellectual ineffectiveness because of increased rigidity and low energy. . ., negative self-image, feelings of personal insignificance and impotency, and a view of self as old. Residents tend to be docile, submissive, show a low range of interests and activities, and to live in the past rather than the future. They are withdrawn and unresponsive in relationship to others."

With the overwhelming numbers of aged in state mental hospitals much of the criticism of institutional effects was focused on them, and the question was raised of how "appropriate" were many of the patient commitments

there. Accordingly programs were developed aimed at screening the aged and finding alternatives to the state mental hospital "by making greater use of other community resources that were believed to be more suitable to the needs of the patients" (Epstein and Simon, 1968). The screening programs have been very successful when measured by their stated goal of reducing hospital admissions. Stotsky (1967) was able to successfully place in nursing homes 81 percent of 141 state hospital aged patients. Epstein and Simon (1968) set up such a pre-admission screening unit in San Francisco General Hospital in 1964 and achieved a striking reduction in state hospital admissions from San Francisco, going from a previous mean base of 450 a year to 40 in 1965, 12 in 1966, and none in 1967. These results confirmed the belief that old people didn't really have to be committed to state hospitals, and could be handled in other facilities, mainly nursing homes.

Epstein and Simon (1968) then proceeded to do a one year follow-up on a three month sample of 99 screened patients who were sent to nursing homes, compared to 436 patients sent to state hospitals prior to the implementation of the screening program. Only patients with no psychiatric illness before age 60 were studied, but there were far more with simultaneous acute and chronic brain syndromes in the state hospital group, 41 compared to 13 percent. They found that of the nursing home population 25 percent had died and 54 percent were still in institutions, while 39 percent of the state hospital patients had died and 36 percent were still institutionalized. Orientation was somewhat better in the state hospital patients. The greatest difference was in the area of self-maintenance, with the state hospital patients far superior to those in nursing homes in such areas as toileting, bathing, grooming and dressing. For example, in the state hospital population 38 percent needed no help in bathing compared to only 7 percent in the nursing home group, and for

dressing without assistance it was 52 percent in the state hospital and only 20 percent in the nursing home. The same direction of difference was even found between the two groups for those patients who were no longer institutionalized, with those who had been assigned to nursing homes doing poorer. No help in bathing was required by 83 percent of the ex-state hospital patients, compared to 68 percent of those who had been in nursing homes.

So powerful was the set that led to the study in the first place that, despite their own evidence that patients placed in other facilities did more poorly, Epstein and Simon (1968) concluded that their hospitalization study "confirms that for elderly mental patients there are alternatives to hospitalization in a state mental hospital." What they fail to state is whether or not they have shown a <u>better</u> alternative to hospitalization. Their study represents a classic problem in evaluation studies, the confusion of means and ends. If placement is regarded as the evaluation criterion, then placing the patients in other than state hospitals indicates a great success. If the functioning of the patient after placement is the evaluation criterion, as it should be, then placement in a nursing home is seen as having a more <u>deleterious</u> outcome. Examination of the same evaluation data can thus be regarded as either showing a good or bad program depending on the conceptual context.

The mistake made by the program to keep the aged out of state hospitals which ends by sending them to an even more deleterious place, the nursing home, is the failure to understand why the hospital was so noxious to start with. Certainly many of the criticisms made of the state mental hospital (such as Goffman, 1957 or Kleemeier, 1963) are even more applicable to nursing homes. The reason for the distortion may be linked to social class characteristics.

Although proprietary nursing homes with welfare cases contain many lower class persons (Kelman, 1962), there are also many private nursing homes with predominantly middle class populations. Since state hospitals are disproportionately represented by lower class and immigrant populations they are subject to the most denigration (Grob, 1966). The mistake is made in assuming that the institution with the most predominantly lower class population is necessarily the poorest.

Another reason for the error may be in naive definition of "in the community." If the state hospital is considered the ultimate in being away from the community, any other facility, especially if more proximal to geographic population centers, becomes automatically considered as in the community and therefore better.

One variation of alternative to hospitalization is a system of coordinated care. Hacker and Gaitz (1972) established a team approach for elderly admissions to the county psychiatric screening ward. They also found they could greatly reduce the proportion of state hospitalization, but that comprehensive care plans were difficult to achieve because of resistance to change and the lack of community resources. They introduced a new twist to evaluation research in that they also measured the evaluation of the team's actions by the patients, families and other caregivers. They found that most patients and families had little appreciation of the value of the team.

There have been few attempts to establish really comprehensive community mental health programs for the aged, and those that have existed have not used control group comparisons which are really critical for evaluation purposes. One of the earliest and clinically most impressive was the program set up by Duncan Macmillan (1958, 1962) at Mapperley Hospital in

Nottingham. With a catchment area of 390,000 people, Macmillan's program emphasized the open hospital, brief, time-limited hospitalization and continuity of care with the same professional following the patient in the hospital and community, with coordination of after care, and emphasis on pre-admission domiciliary visitation for the aged. A geriatric day center was also established. With this combination of activities he felt that progress was made in prevention. He found that the interaction between the old person and the responsible relative was more important than the degree of senile psychosis in committing a patient to the hospital. A person with a severe organic brain syndrome could function outside the hospital in a favorable family setting. Lowenthal and Berkman (1967) in the San Francisco geriatric survey reported similar findings -- that many persons who were as severely impaired as their hospitalized sample were able to be maintained in the community if there was an involved caretaker. They found that a major cause of hospitalization was the breakdown of the caretaking services that were maintaining the old person in the community, rather than an increase in psychopathology, a situation which could be prevented in many cases by the supportive services of a comprehensive program. Given the problem with discharge figures, and the lack of mortality data, Macmillan does report that with more than 25 percent aged patients of a total of 1,196 patients admitted in 1954, only eleven were still in the hospital three years later.

Traditionally many studies of mental health services for the aged have focused on operations within encapsulated or total institutions -- the state hospital, the nursing home, the home for the aged. But the very use of these facilities has been challenged by some of the newer conceptions of community mental health. The two major criticisms of these institutions

is 1) that they present too limited a treatment alternative and 2) that what is really needed is a comprehensive system of care which includes many alternatives and continuity of care in relating to the different components. Some of the newer ideas have been expressed by Daniels and Kahn (1968) and in the Guide to Program Development put out by the Group for the Advancement of Psychiatry (1971). Actual programs which have attempted to put these ideas into practice are those of Macmillan (1958), Perlin and Kahn (1968) and Whitehead (1970). In these new programs some evaluation criteria that may have had some validity in the past are now meaningless. Discharge from an institution, duration of hospitalization and readmission are good examples of variables which should be regarded as criteria of treatment rather than outcome. In a flexible program it may be considered worthwhile to have many brief admissions rather than one protracted hospitalization. The many admissions would reflect the flexibility of the program rather than the pathology of the patient.

Of course such a comprehensive program as Macmillan's presents evaluation problems because it also involves a community and a change in attitude at all levels, so that an experimental-control group design is not feasible. It would obviously require comparisons of an entirely different community that differs in basic components of the geriatric program.

Another evaluation problem in a comprehensive program is the impact of "potential therapy," in which a commitment to service may be a significant part of the program, but is not as easy to measure as direct service. Macmillan (1958), for example, committed himself to a program of "holiday relief," in which he guaranteed a family that he would hos-

pitalize an aged person when it was desired so the others could take a vacation. In the Montefiore program (Perlin and Kahn,1968) guarantees were made for hospitalization or any other mental health services to the aged when needed. A somewhat similar approach was described by Brody and Cole (1971) in working with applicants to a home for the aged. In selected cases the applicant was not immediately admitted but put on deferred status, keeping his place on the waiting list but assured that if necessary there would be more rapid admission than for a new applicant. They reported that 70 percent were still living at home 14 months later and only 22 percent had been admitted. Theoretically, by virtue of providing this commitment to potential service, the pressure on the patient and his family can be considerably eased. They may test the commitment to see how firm it is, but then seem to be able to have less need of the service by virtue of the very promise of more of it.

The Criteria of Evaluation: Further Issues

The Contented vs. the Angry Patient

Many studies assume that criteria such as subjective feelings of comfort or contentment are indicative of improvement. Although this may be relatively valid when dealing with severe depression, negative feelings may sometimes be more significant. Several studies have shown that the best outcome was shown by persons who were angry (Aldrich and Mendkoff, 1963; Turner et al., 1972; Kleban and Brody, 1972; Gottesman, 1965.) Naive notions of hope, happiness or life satisfaction may be more related to denial (Scott, 1970; Haberland, 1972) which can be regarded in both positive and negative terms.

Deterioration

Although we think of mental health intervention studies in terms of positive results in which there is some improvement in behavior, there is substantial evidence that many programs have harmful consequences. In reviewing the literature on psychotherapy studies, Bergin (1971) has pointed out that in a high proportion as many clients deteriorate as improve. In a review of all evaluation studies of casework using control groups, Fisher (1973) found that about half showed deterioration in the experimental group. Similarly, there is much deterioration reported in the aging studies. In the Epstein and Simon (1968) study, the experimental group placed in nursing homes instead of state hospitals showed poorer self-maintainance. Cautela (1969) and Grossman and Kilian (1972) have shown that negative effects can be produced in behavior modification studies. But perhaps the most important demonstration of harmful effects can be found in several studies of Margaret Blenkner.

In an early study (Blenkner et al., 1964), she and her colleagues evaluated an experiment to test the effects of social work and public health nursing services for non-institutionalized aged. The participants had been randomly assigned at the point of application for service into a minimal program consisting of providing information and referral, or an intensive program of direct service in which both the social worker and nurse were more active, or a program that fell in between on amount of service. At a six-month follow-up it was found that the maximal service group had twice the death rate of the middle group, and four times the rate of the minimal program, the rates ranging from 6 to 24 percent. As an explanation of this striking result they noted that persons in the maximal service were much more likely to have been offered a service providing

a more protected environment. From this result they formulated the hypothesis that: "There is a negative association between placement and survival among older persons which prevails even when their physical condition is held constant."

In a later study Blenkner et al. (1970) studied a sample of 164 aged persons who were referred to various community agencies for protective services. A control group of 88 subjects received ordinary community services, while the experimental group of 76 randomly assigned subjects received a highly developed demonstration service with experienced case-workers directed toward maintaining them in their own homes and involving a battery of ancillary project services such as a home aide service. The outcome was operationalized in terms of four major aspects: competence, environmental protection, affect and effect on others. The data was collected through structured interviews and ratings by observers. At a one year follow-up there were no significant differences on most measures, but the experimental group did better on measures of the adequacy of the physical environment and relief of stress on collaterals, both because of a higher rate of institutionalization. At this time, however, it was thought that the experimental group was beginning to show an accelerated decline. By the time of the five-year follow-up the experimental group showed significantly higher rates of institutionalization and death.

These deteriorative results seem to run counter to what could have been reasonably expected. The program sounds like as progressive a one as could be defined today, making use of trained workers and a variety of social agencies and aimed toward keeping the aged out of institutions. Why, for example, shouldn't the results be as good as in Macmillan's program? This may be a complex question which has many relevant answers,

but we might suggest one. The caseworker in the Blenkner study had to deal with many different agencies in the community, the coordination of which is very difficult as Gaitz and Hacker (1970) have shown. The administrative and other coordination difficulties can lead the caseworker with limited alternatives no choice but to turn to the institution when the problems appear to be too great. In Macmillan's program he had the law especially changed so that hospital and community care were not separated, with the staff having "double appointments" in the hospital and the Ministry of Health. In this way the hospital was a resource rather than the end point of frustration, and the patient was quickly discharged with the same personnel at all times maintaining the continuity of care.

Covert Deterioration: Limited and Basic Goals

Death as an evaluative criterion is an obvious example of overt deterioration. This can also be shown by such criteria as decline in mental status and self-maintenance. But we would like to suggest that covert deterioration must also be considered, that this is a critical factor in mental health studies but unfortunately one that is subtle and therefore conceptually controversial and operationally difficult to demonstrate. A good example of the phenomenon is cited by Alexander (1964) as a problem in psychoanalytic treatment. The analyst may induce a dependent relationship in order to establish transference which he feels is a necessary step for successful treatment. But he may then have no way of providing for the person to take over and make the therapist unnecessary. This subversion of the goal of independent functioning means that the very success of the treatment in a limited sense means the failure of the treatment in a more basic sense. It is unfortunately, almost literally exact to cite the old medical gag that the treatment was a

a success but the patient died.

The distinction between overt and covert measures of deterioration is one aspect of an important problem in all mental health programs -- the difference between limited and basic goals. This problem is particularly important for those who deal with the aged. It is this difference in perspective that accounted for the contrasting perception of the trustees and researchers cited at the beginning of this chapter. It is this disparity that accounts for many of the sharply different orientations among professionals toward the use of institutions. This issue has also been touched upon in the discussion of intra-institutional intervention studies, where it was pointed out that many ostensibly reasonable treatment goals, such as increased sociability or changed attitudes, are irrelevant when viewed in the light of institutional effects and their significance for longer-term changes in individual functioning. We will attempt to clarify the issue by consideration of a number of important alternative evaluation criteria in which there are issues of covert deterioration.

Analogous to the dilemma posed by Alexander for psychoanalysts is a situation common in dealing with the aged. It is obvious that the older person has increasing dependency needs, but a treatment plan which caters to the dependency needs may undermine the necessary requirements of independent functioning.

The mere act of institutionalization intensifies dependency aspects, and ameliorative efforts within the institution may actually make it harder for the person to leave. Nursing homes, after all, are organized around the function of "caring" for their patients, and will conceptualize amelioration as providing better care. To cite a concrete example, dressing

may be a slow, painful task for many older persons, but the well-meaning assistance of nursing staff can result in the person's losing the capacity to dress independently. An occupational therapy program to teach dressing skills is likely to be undermined by the ready availability of assistance, and by a staff, since its function is caring, that will want to assist. That kind of process probably accounts for Epstein and Simon's (1968) finding, that state hospital patients were better in self-care activities than those in nursing homes, since the more independent behavior in a nursing home may actually, in some situations, be viewed as an administrative problem, and thereby discouraged (Goldfarb, 1964).

Many programs have attempted ameliorative effects with chronically institutionalized populations with questionable results. If, in fact, so much of the behavior of the aged person is the effect of the institutionalization rather than mere changes in the individual, then the best way to treat it would be to prevent it from happening in the first place. The expenditure of major effort at an ameliorative level may only obscure the most effective way to deal with the problem. Prevention rather than amelioration or restitution may be the most important approach to such populations. The trap is that, granted that prevention is a large part of the answer, what do we do with those patients who are in institutions right now. Although they should certainly be treated humanely, any substantial expenditure of time or money in such settings would only be reinforcing the wrong system, and lead to the continued use of those institutions by subsequent aged populations with the same deleterious consequences. Making the institution a more pleasant place is an extremely limited goal compared to the more harmful effects of its continued operation.

An important practical problem in our current system concerns the definition of a good nursing home. We once visited a nursing home that had been described in the literature as outstanding. Its exceptional qualities were that it had a clinical conference once a week which included a patient's doctor, that the aides were paid extra salary for two hours a week to come in for in-service training, and that there was an active volunteer program. The clinical conference was pedestrian, the in-service time was spent on a discussion of the Menninger system of classification of mental disorders, and the volunteer was a weak-voiced woman reading out of a dull book to withdrawn and unresponsive patients. In a two-storey structure with 47 beds there was a dining room which seated six, no elevator, and access to the second floor only by a steep flight of stairs. The patients were as deteriorated as could be found in any other nursing home with private patients.

This experience exemplifies a fundamental problem in evaluation, whether the criteria should be based on the institutional characteristics or the patients' behavior, or both. With the vast proliferation of proprietary nursing homes there has been much concern with quality and standards. Kosberg and Tobin (1972) surveyed 214 nursing homes in the Metropolitan Chicago area and found that the treatment resources, such as professional staff characteristics, facilities and equipment, were highly associated with organizational characteristics such as source of payment and referral. The authors seem quite confident that they can formulate standards for nursing home operations. Others such as Beattie and Bullock (1964) and Homburger and Bonner (1964) likewise formulate criteria for nursing home evaluations emphasizing such criteria as staff ratios and Tender Loving Care.

These criteria can best be described as "window dressing," satisfying the needs of relatives, staff, board members, and local government regulating agencies, to see the facility as a clean and pleasant place. None of the rating systems is based on evaluation studies of what actually happens to patients subject to these different programs. There are institutions, for example, where high staff ratios facilitate custodialism. By avoiding dealing with the actual fate of their patients and with no control group studies they are able to perpetuate their own wishful thinking. The mental health and aging fields have plenty of this kind of uncritical thinking in which the instrumental technique assumes more importance than the end result. It is likely that as an encapsulated institution the nursing home can have only limited usefulness. The really critical factor may be the degree to which the institution is part of a comprehensive system of care. It may be that a poorly staffed nursing home that is integrated in a comprehensive system will have better results than a well-staffed encapsulated institution.

One of the sources of bias affecting judgment of institutions and programs is the social class characteristics of the patients. Social class is related to morbidity, type of pathology, amount and kind of treatment, and therapeutic outcome following treatment (Hollingshead and Redlich, 1958; Srole et al., 1962; Leighton et al., 1963; Kahn et al., 1959). Institutions tend to select certain kinds of populations because of their auspices and status value. In a study of Homes for the Aged, Goldfarb (1962) found an enormous range in the quality of the residents of the different homes. These differences reflected the social class composition of the residents who tended to be relatively homogeneous in each setting and ranged from poorly-educated foreign born to those who were native-born

and had a superior cultural background. Although it is true that the social character of the residents influence the character of the program, it is a common error to rate institutions by criteria which reflect some of the trappings of the social differences rather than any independent qualities of the program. This type of error is very common in evaluating nursing homes, in which those with private patients are seen as superior to those with welfare residents. The basis for the reputation of many homes for the aged seems to depend on the social background of their residents.

Much of the services available to the aged are based on the premise of custodialism. According to this premise, what is necessary is a benign setting which takes care of the patient's basic needs, provides minimal medical care, has no expectation of improvement and will continue until the patient's death. In such a context even therapy programs, as occupational or recreational therapy, serve a custodial role, making the adaptation to the setting more tolerable.

In contrast to this conception, an expectation of improvement would lead to much different treatment. Going into an institution would be specified as a temporary component of a total program in which the aim is the therapeutic goal of restoring or enhancing independence. In a custodial context an institution becomes a container; in a therapeutic setting it will be a revolving door. It is not that institutions are inherently bad, since they can serve a very important role dealing with certain brief critical periods. An old person should only be confined to a custodial setting when all other measures have failed. In such a system it is believed that the actual number who need custodial care will be considerably reduced.

The relationship of the needs of the patient and his family raises some critical questions in evaluation but which are generally not even considered. The nature of the program seems to determine whether there is complementarity or conflict in meeting the needs of the patient and his family. Macmillan uses institutionalization as a way of responding to the family's need, while maintaining the interests of the patient. For example, as mentioned earlier, one service he provided was "holiday relief," according to which he would hospitalize the patient for a brief period, not because of any clinical need, but in order to enable the family to take a holiday. He thus uses brief hospitalization as a way of preventing long hospitalization which might be necessary without such flexible support. But the traditional, restrictive system of care with few alternatives creates a situation in which the needs of the patient and his family, or society, may be in conflict. Relief of stress on the collaterals has been reported by Blenkner et al. (1971) and by Grad and Sainsbury (1968), in which while the family "improved", the patients were not doing too well. It is clear that there is a different goal and evaluation criteria depending on whether one looks at institutionalization from the point of view of the patient or his family and society. A patient who has difficulties which are excessively taxing his family, or who has problems because he doesn't have family supports, will then have to be institutionalized. Solving the family or social need, however, often leads to the patient's decline and death. In one sense, because of present limitations of service, we cannot take a moral stand on this dilemma, as at times it may be more desirable to protect the family's or the patient's interest. A successful outcome for one may mean a

disaster for the other so that the evaluation depends on your perspective. In Macmillan's type of program there is much more opportunity for helping both.

Conclusions

1. Most mental health studies with the aged have been designed to improve functioning of institutionalized populations, partly because of their easy accessibility. Although outcomes are generally considered positive by the experimenters, the results are questionable by virtue of population selectivity, lack of control groups, vague or inappropriate criteria, transitory outcomes, and "Hawthorne effect" artifacts. The most elaborate and carefully designed studies show negative or minimal results.

2. Prevention may be more effective than restitution or amelioration in countering the effects of institutionalization.

3. Some of the attempts at prevention of institutionalization are either providing alternative kinds of treatment on admission to the hospital, such as an age-integrated ward, or actual alternatives to hospitalization. Although these show some promising results, there has been confusion in the differentiation of critical variables, so that such factors as admission, discharge, duration of treatment, or readmissions are incorrectly seen as outcome instead of intervention variables.

4. Not only do many outcomes show doubtful improvement, but the experimental group, in many studies, may be more deteriorated in function than the controls.

5. In addition to overt deterioration, covert deterioration is an

important evaluation component, characterized by improvement in a limited function, while deteriorating with respect to a more basic goal. The very qualities, for example, that contribute to a person's adaptability in an institution interfere with his capacity to function independently outside the institution.

6. The confusion of limited and basic goals is widespread, with such absurdities as evaluating institutions by their resources and organization, rather than by what happens to the patient.

7. Other conspicuous criteria problems are mistaking the social class characteristics of the patient for the quality of the program, or failing to differentiate the purpose of a program for the usually antagonistic goals of helping the family or the patient.

8. It is considered that the best hope for the future is a comprehensive mental health system, with many flexible alternatives, integration of community and institution, and continuity of care. All of these terms, however, can be clichés, receiving much lip service and little substance. An interagency cooperative operation may be so difficult to achieve that a program can result in more harm than good. When a crisis develops in such a situation, the staff may utilize traditional interventions, despite their community-treatment ideology.

9. Comprehensive mental health programs are hard to establish, and present complicated problems in evaluation. Some programs, however, have been achieved which seem vastly superior to traditional practices, but good evaluation studies of these remain to be done.

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